IN THE UNITED STATES PATENT OFFICE

In re patent application of:	)	
	)	
Dean F. Boyer et al.	)	Before the Examiner
	)	Lindsay M. Maguire
Application No. 09/690,940	)	
	)	Group Art Unit 3692
Filed: October 18, 2000	)	
	)	June 23, 2008
POINT OF SERVICE THIRD PARTY FINANCIAL MANAGEMENT VEHICLE FOR THE HEALTHCARE INDUSTRY	)	

APPEAL BRIEF

Commissioner for Patents
P.O. Box 1450
Alexandria, VA 22313-1450

Sir:

Pursuant to the Notice of Appeal submitted to the United States Patent Office on April 23, 2008 in connection with the above-indicated application, an Appeal Brief according to 37 CFR §41.37 is provided along with the requisite fee of $500.00 for a large entity. The Commissioner is authorized to grant any further extensions of time, and charge any deficiency or credit any overpayment to Deposit Account No. 23-3030, but not to include issue fees.

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I. REAL PARTY IN INTEREST

(37 CFR §41.37(c)(1)(i))

The real party in interest in this appeal is RealMed Corporation, which is the owner of the present application by written assignment recorded at reel/frame number 012613/0900.

II. RELATED APPEALS AND INTERFERENCES

(37 CFR §41.37(c)(1)(ii))

The applicants, the applicants' legal representative, and the assignee are unaware of any related appeals or interferences which will affect, be directly affected by, or have a bearing on the Appeal Board's decision in the present appeal.

III. STATUS OF CLAIMS

(37 CFR §41.37(c)(1)(iii))

A. TOTAL NUMBER OF CLAIMS IN APPLICATION

Claims in the application are 64.

B. STATUS OF ALL THE CLAIMS

1. Claims canceled: 1-47
2. Claims withdrawn from consideration but not canceled: none
3. Claims allowed: none
4. Claims rejected: 48-111
5. Claims objected to: none

C. CLAIMS ON APPEAL

The claims on appeal are: 48-111

IV. STATUS OF AMENDMENTS

(37 CFR §41.37(c)(1)(iv))

An amendment was filed on April 23, 2008, which was after the date of the Final Office Action mailed November 19, 2007. The amendment corrected informalities in claims 91 and 107 that were noted by the Examiner in the Final Office Action in order to place the claims in better form for appeal. The amendment was entered by the Examiner on May 14, 2008.

V. SUMMARY OF CLAIMED SUBJECT MATTER

(37 CFR §41.37(c)(1)(v))

The following summarization explains how each of the independent claims reads on one or more embodiments of the present application. In this summarization, all figure designations refer to the present application, and all page and line numbers refer to the corresponding text of the present application. It should be appreciated that the below summaries are to be interpreted as merely nonlimiting examples--it being understood that all other embodiments upon which the claims read are also intended to be covered.

A. Independent Claim 48

Independent claim 48 sets forth a system that reads on several embodiments of the present application. For instance, the system includes a point of service terminal for receiving a payment system access card, the point of service terminal being coupled to a network (see page 10, line 16 through page 12, line 11 and FIG. 1). The system also includes an adjudication engine to produce a substantially real-time adjudicated settlement transaction (see page 12, line 17 through page 13, line 24; page 13, line 31 through page 17, line 7 and FIGs. 1 and 2). Finally, the system further includes a payment system that received the substantially real-time adjudicated settlement transaction and debits, substantially in real time, the payment access card for a third party payment amount (see page 13, lines 25-30 and FIG. 1).

B. Independent Claim 60

Independent claim 60 sets forth a method that reads on several embodiments of the present application. For instance, the method includes receiving a payment system access card at a point of service provider (see page 20, line 29 through page 23, line 5 and FIG. 4). The method also transmits a purchase transaction substantially in real-time to an adjudication engine that substantially in real-time produces an adjudicated transaction (see page 24, line 24 through page 25, line 28 and FIG. 4). The method further receives an adjudicated transaction in substantially real-time comprising an indication of the covered portion to be paid by the third party (see page 25, line 29 through page 26, line 20 and FIG. 4). The method further debits the access card

substantially in real-time for the covered portion that is to be paid by the third party (see page 26, lines 21-33 and FIG. 4).

C. Independent Claim 67

Independent claim 67 sets forth a method that reads on several embodiments of the present application. For instance, the method includes receiving a purchase transaction from a point of service provider, the purchase transaction generated at least in part by a purchase of at least one of a service and a product, at least a part of the purchase being reimbursable by a third party (see page 20, line 29 through page 23, line 5 and FIG. 4). The method also adjudicates the purchase transaction to produce an adjudicated transaction (see page 24, line 24 through page 25, line 28 and FIG. 4). The method further transmits an indication of the covered portion to be paid by the third party to the point of service provider substantially in real-time (see page 25, line 29 through page 26, line 20 and FIG. 4). The method further debits the access card for the covered portion that is to be paid by the third party, wherein the transfer funds indication is received by the point of service provider at the time of the purchase (see page 26, lines 21-33 and FIG. 4). Finally, the method initiates a transfer of funds at the time of the purchase (see page 26, lines 21-33 and FIG. 4).

D. Independent Claim 79

Independent claim 79 sets forth a computer data signal embodied in a carrier wave that reads on several embodiments of the present application. For instance, the computer data signal includes a third party payment amount due from a third party benefit provider to a point of service provider for payment of at least one of a medical service or product (see page 25, line 29 through page 26, line 20 and FIG. 4).

E. Independent Claim 83

Independent claim 83 sets forth a method that reads on several embodiments of the present application. For instance, the method includes receiving a computer data signal embodied in a carrier wave comprising an amount due from a third party to a point of service provider for payment of at least one of a medical service or product (see page 20, line 29 through

page 26, line 20 and FIG. 4). The method further debits a payment system access card for the third party payment amount in response to the computer data signal at the time of said purchase (see page 26, lines 21-33 and FIG. 4).

F. Independent Claim 87

Independent claim 87 sets forth a system that reads on several embodiments of the present application. For instance, the system includes an adjudication engine to produce a substantially real-time adjudicated settlement transaction substantially at the time of purchase (see page 12, line 17 through page 13, line 24; page 13, line 31 through page 17, line 7 and FIGs. 1 and 2). Also, the system further includes a payment system that received the substantially real-time adjudicated settlement transaction and initiates reimbursement of the third party payment amount to the service provider, substantially at the time of the purchase transaction (see page 13, lines 25-30 and FIG. 1; page 25, line 28 through page 26, line 33 and FIG. 4).

G. Independent Claim 99

Independent claim 99 sets forth a method that reads on several embodiments of the present application. For instance, the method includes receiving at a payment system an adjudicated purchase transaction at a point of service provider at the time of purchase, the adjudicated purchase transaction is for at least in part a good or service provided to a beneficiary of a third party benefit provider (see page 20, line 29 through page 26, line 20 and FIG. 4). The method further initiates a funds transfer in accordance with the adjudicated transaction for payment of at least a covered portion from an account administered by the third party, wherein the funds transfer is initiated substantially in real-time (see page 26, lines 21-33 and FIG. 4).

VI. GROUNDS OF REJECTION TO BE REVIEWED ON APPEAL

(37 CFR § 41.37(c)(vi))

A concise statement of each ground of rejection presented for review is provided below.

A. WHETHER CLAIMS 92 AND 93 COMPLY WITH THE WRITTEN DESCRIPTION REQUIREMENT UNDER 35 U.S.C. §112, FIRST PARAGRAPH.

B. WHETHER CLAIMS 48-111 ARE INDEFINITE 35 U.S.C. §112, SECOND PARAGRPAH FOR FAILING TO PARTICULARLY POINT OUT AND DISTINCTLY CLAIM THE SUBJECT MATTER WHICH APPLICANTS REGARD AS THE INVENTION.

C. WHETHER CLAIMS 48-52, 54-56, 60-62, 67-71, 73-74, 78-79, 83, 87-90, 94, 95 AND 96-98 ARE UNPATENTABLE UNDER 35 U.S.C. §103 OVER BARBER ET AL, IN VIEW OF LITTLE ET AL. AND FURTHER IN VIEW OF PHI.

D. WHETHER CLAIMS 53, 57-59, 63-66, 72, 75-77, 80-82, 84-86, 91 AND 99-111 ARE UNPATENTABLE UNDER 35 U.S.C. §103 OVER BARBER ET AL, IN VIEW OF LITTLE ET AL. AND FURTHER IN VIEW OF PHI AND FURTHER IN VIEW OF SACKLER ET AL.

VII. ARGUMENT

(37 CFR § 41.37(c)(vii))

The contentions of the applicant and the basis for those contentions with respect to each ground of rejection is presented below.

A. REJECTIONS UNDER 35 U.S.C. §112, FIRST PARAGRAPH

1. Claim 92

Claim 92 was rejected under 35 U.S.C. §112, first paragraph for allegedly failing to comply with the written description requirement since the recitation "wherein at least a portion of said payment is from a pre-funded account" is not present in the specification (Final Office Action, pages 2-3). Applicants respectfully traverse. The present specification specifically states that "the employer may issue a securitized card" (see specification, page 17, line 18). As is well-known in the credit card art, a securitized card is pre-funded so that the user does not have to rely on credit-worthiness to receive a payment card. It is therefore respectfully submitted that Applicants' claim 92 is allowable under 35 U.S.C. §112, first paragraph.

2. Claim 93

Claim 92 was rejected under 35 U.S.C. §112, first paragraph for allegedly failing to comply with the written description requirement since the recitations "first third party payer" and "second third party payer" are not present in the specification (Final Office Action, pages 2-3). Applicants respectfully traverse. The present specification specifically states that the adjudication engine allocates "the policy deductible(s), co-pay, *co-insurance*, and any uncovered

amounts" (emphasis added; see specification, page 28, lines 2-4). As is well-known in the insurance art, the term "co-insurance" indicates that the patient has more than one insurance policy that may cover the treatment, therefore indicating that there may be a "first third party payer" and "second third party payer." It is therefore respectfully submitted that Applicants' claim 93 is allowable under 35 U.S.C. §112, first paragraph.

B. REJECTION OF CLAIMS 48-111 UNDER 35 U.S.C. §112, SECOND PARAGRPAH FOR FAILING TO PARTICULARLY POINT OUT AND DISTINCTLY CLAIM THE SUBJECT MATTER WHICH APPLICANTS REGARD AS THE INVENTION.

1. Claims 48-111

Applicants respectfully disagree that the use of the word "substantially" in claims 48-78 and 87-111 and "approximately" in claims 79-86 are "relative terms which render the claims indefinite." Taken as a whole, in context of the disclosure and the ordinary meaning of the words used, the phases "in approximately real-time" and "in substantially real-time" are understandable to one of ordinary skilled in the art and supported by Applicant's specification. The adjectives "approximately" and "substantially" are within the vernacular and understanding of those of ordinary skill in the analogous art. Just as the terms "real-time" and "near real-time" are relative terms that are well known by those of ordinary skill in the art, the phases "substantially real-time" and "approximately real-time" are within the grasp of those of ordinary skill in the art to understand.

Non-limiting examples of the ordinary meaning of the adjective "approximately", as provided by various dictionaries, may include: "very similar; closely resembling"; "almost exact

or correct"; "nearly the same as"; "near or approaching a certain state, condition, goal, or standard"; "nearly exact; not perfectly accurate or correct: The approximate time was 10 o'clock";" near; close together"; and "very similar; nearly identical." Moreover, the ability of those of ordinary skill in the art to understand temporally relative terms such as "real-time" and "near real-time" demonstrate the ability of those of ordinary skill in the art to understand and perceive relative descriptions of time. As a result, Applicant respectfully submits that Applicant's description of the preferred embodiment combined with the ordinary meaning of the words sufficiently defines the claimed at issue within the scope and meaning of 35 U.S.C. § 112, second paragraph.

Applicant notes that the Examiner did not object to Applicants' previously submitted claims 24 or 36, now cancelled, which used the phase "substantially in real-time." In addition, Applicant respectfully submits that Applicant's specification uses the phase "substantially in real-time" throughout. Likewise, Applicant's use of the word "substantially", "real-time", "time" and the phrase "substantially in real-time" throughout the specification provides sufficient context and meaning for one skilled in the art to ascertain the temporal meaning of the claims 48-111.

Applicant submits that the suggestion that a claim must define the exact time, e.g., "five seconds, 10 seconds, one minute or less," relates to implementation details. Applicant respectfully submits such implementation details are not required by 35 U.S.C §112, second paragraph. Furthermore, Applicant submits that Applicant's teaching sufficiently defines, encompasses, enables, and describes "in approximately real-time" and "in substantially real-time."

It is therefore respectfully submitted that Applicants' claims 48-111 are allowable under 35 U.S.C §112, second paragraph

C. REJECTION OF CLAIMS 48-52, 54-56, 60-62, 67-71, 73-74, 78-79, 83, 87-90, 94, 95 AND 96-98 UNDER 35 U.S.C. §103 OVER BARBER ET AL. (US 4,858,121), IN VIEW OF LITTLE ET AL. (US 5,389,509) AND FURTHER IN VIEW OF NEWSWIRE (PR NEWSWIRE, "Speedware, Prospective Health Inc., Announce Reseller Agreement." New York: Jan. 20, 1998. p.1; 2 pages).

1. STATEMENT OF LAW

When considering an application, the patent law presumes that unless the claimed subject matter is within the prior art, in other words accessible by the public, an Applicant is entitled to receive the requested patent protection.

The Examiner has the initial burden to factually show *prima facie* obviousness. *See* MPEP § 2142. "If the examiner does not produce a *prima facie* case, the applicant is under no obligation to submit evidence of nonobviousness. *See* id. To meet the burden require to show prima facie obviousness, the rejection must show that (1) the relied upon analogous prior art references teach or suggest all the limitations of the claim at issue; (2) the prior art provides a suggestion or motivation to modify the reference or to combine reference teachings; and (3) there is a reasonable expectation of success. *See* MPEP § 2142.

The statements and teaching found in the prior art may not be viewed in the abstract. *See c.f. In re Kotzab*, 55 U.S.P.Q.2d 1313, 1317 (Fed. Cir. 2000). Instead, prior art "must be considered in the context of the teaching of the entire reference." *See* id. Furthermore, "a rejection cannot be predicated on the mere identification ... of individual components of

claimed limitations. Rather, particular findings must be made as to the reason the skilled artisan, with no knowledge of the claimed invention, would have selected these components for combination in the manner claimed." *In re Kotzab*, 55 U.S.P.Q.2d 1313, 1317 (Fed. Cir. 2000).

Proper obviousness analysis requires the claimed subject matter be considered "as a whole without the benefit of hindsight and the claims must be considered in their entirety." *Rockwell Int'l Corp.*, 147 F.3d at 1364. Thus, "all words in a claim must be considered in judging the patentability of that claim against the prior art." *In re Wilson*, 424 F.2d 1382, 1385, 165 USPQ 494, 496 (CCPA 1970), *see* MPEP § 2143.03. Consequently, a limitation or element may not be considered in isolation. Instead, the elements or limitations of the each claim must be considered together as a whole. *See id.* A claimed invention is not obvious unless the analogous prior art teaches or suggests *all the claim limitations*. *See In re Royka*, 490 F.2d 981, 180 USPQ 580 (CCPA 1974) (emphasis added). **Unless the analogous prior art provides a suggestion or motivation to make or use the claimed invention, a rejection based upon 35 U.S.C. 103 is inappropriate.** *See* MPEP 2116.03 (emphasis added). The motivation or suggestion to make the claimed combination may not glean the from the Applicant's disclosure. *See In re McLaughlin*, 443 F.2d 1392, 1395, 170 USPQ 209, 212 (CCPA 1971); s*ee also* MPEP § 2145; s*ee also* MPEP § 2142, *In re Vaeck*, 947 F.2d 488, 20 USPQ2d 1438 (Fed. Cir. 1991). Instead, the requisite motivation must be provided by some teaching, suggestion or inference in the analogous prior art as a whole or from the knowledge generally available to one of ordinary skill in the art. *See Uniroyal, Inc. v. Rudkin-Wiley Corp.*, 837 F.2d 1044, 1052, 5 USPQ2d 1434, 1439 (Fed. Cir.), cert. denied, 488 U.S. 825 (1988). In addition, the level of skill in the art may not be used to provide the suggestion to the cited combined references. *See* MPEP § 2143.01 (citing *Al-Site Corp. v. VSI Int'l Inc.*, 174 F.3d 1308, 50 USPQ2d 1161 (Fed. Cir. 1999)).

Moreover, a reference may not be used in a manner that changes the fundamental character of the reference being modified. *See* Beachcraft v. Broyhill Furniture Industries Inc., 681 F.Supp. 1190, 1215 (N.D. Miss. 1988) (holding that "the modification necessary to the primary reference in order to achieve the patented design may not destroy fundamental characteristics of the primary reference.") The inherent temptation to slip into the use of hindsight or read the Applicant's teaching into art must be avoided and resisted.

Moreover, "[t]he mere fact that references can be combined or modified does not render the resultant combination obvious unless the prior art also suggests the desirability of the combination." MPEP § 2143.01 (emphasis in original) (citing *In re Mills*, 916 F.2d 680, 16 USPQ2d 1430 (Fed. Cir. 1990)). Instead, the proper inquiry is "whether there is **something in the prior art as a whole to suggest the desirability**, and thus the obviousness, of making the combination..." *See In re Fulton*, 391 F.3d 1195, 73 USPQ2d 1141, 1200-01 (Fed. Cir. 2004) (emphasis added); *see also* MPEP § 2143.01.

Finally, "the teaching or suggestion to make the claimed combination and the reasonable expectation of success ***must both be found in the prior art.***" MPEP § 2142 (citing *In re Vaeck*, 947 F.2d 488, 20 USPQ2d 1438 (Fed. Cir. 1991)) (emphasis added). Said differently, to establish prima facie obviousness, the cited art must prove that one of ordinary skill in the art could have possessed and practiced the claimed invention.

Thus, when applying 35 U.S.C. 103, the following tenets of patent law must adhere to:

(A) the claimed invention must consider as a whole, including all claim elements and limitations, but not merely as a mosaic of individual elements;

(B) the analogous prior art must show every limitation of the claim at issue;

(C) the analogous prior art must show some suggestion or motivation in the analogous prior art to combine the specific elements shown in the references;

(D) the analogous prior art must establish that one of ordinary skill in the art would believe the proposed combination or modification had a reasonable expectation of success;

(E) the references must be viewed without the benefit of impermissible hindsight vision afforded by the claimed invention or relying upon the skill in the art; and

(F) each reference must be considered in its entirety and in the context of what one of ordinary skill in the art would have understood at the time of the invention.

In addition, when determining the "scope and content of the prior art", ascertaining "differences between the prior art and the claims at issue," and resolving "the level of ordinary skill in the pertinent art," the Examiner must also consider "such secondary considerations as commercial success, long felt but unsolved needs, failure of others, etc., [that] ... give light to the circumstances surrounding the origin of the subject matter sought to be patented." *See* Graham v. John Deere, 383 U.S. 1, (1966) (outlining "Graham Factors"); see also MPEP § 2141.

Finally, a dependent claim is not obvious when the independent claim that the dependent claim references is non-obvious. *In re Fine*, 837 F.2d 1071, 5 USPQ2d 1596 (Fed. Cir. 1988).

2. CLAIMS 48-52, 54-56, 60-62, 67-71, 73-74, 78-79, 83, 87-90, 94, 95 AND 96-98 ARE NONOBVIOUS.

i. Barber does not Show or Suggest a Payment Access Card

The Examiner states that "Barber discloses a medical payment system comprising a network (Fig 1; Column 1, lines 63-65). A point of service terminal comprising a point of service

terminal network interface operably coupled to said network (Column 1, lines 61-65) and adapted to provide an indication of a purchase transaction and a card interface to receive said **payment access card for payment of a purchase** of at least one service and product to said point of service provider (Column 2, lines 10-14 and Column 4, lines 10-20; see "smart cards"), wherein at least part of said purchase is reimbursable by a third party (Column 2, lines 21-25)." (emphasis added; see Final Office Action p. 4). It is respectfully submitted that Examiner has misinterpreted Barber. Instead, Barber discloses "a plurality of physician terminals, which are located in physicians' offices, are interconnected with a central processing system." *See* Barber, Col. 1, ll. 63-65. Furthermore, the "terminal includes the means for entering at least a patient identification" wherein the patent identification card may include the "patient identification and the insurance company identification." *See* Barber, Col. 1, l. 65 – col. 2, l. 1. While the card disclosed in Barber can provide patient identification, Barber does not disclose "a payment system access card" that can be debited for a covered portion that is to be paid by the third party to the service provider. Instead, Barber discloses that "**when funds are received from the insurance company**, whether by check or electronic funds transfer, the central processing system B communicates directly or by printed authorization with the computers of banks and other financial institutions to transfer the appropriate funds to the account of each physician." *See* Barber, Col. 3, ll. 62-67 (emphasis added). Hence, Barber teaches a "patient identification card" that is separate from a payment card or credit card. Barber neither teaches, suggests nor motivates a payment system access card that may be debited to provide reimbursement from a third party.

ii. <u>Little does not Show or Suggest Substantially or Near Real-Time</u>

In the Final Office Action, the Examiner admits that "Barber does not explicitly disclose an adjudication engine…adapted to receive said indication of said purchase transaction and produce an adjudicated settlement transaction…substantially in real-time. " (see Final Office Action, page 5). The Examiner attempts to cure this deficiency in Little by stating that "Little discloses a health care payment adjudication and review system that discloses an adjudication apparatus for health care payments that teaches all the steps of receiving, and producing a settlement for medical service or product." (see Final Office Action, p. 5) The Final Office Action does not allege that Little shows or suggests doing any of these things substantially in real time. In fact, Little merely espouses improved medical analysis efficiency through the use of an expert system to manage documents in lieu of the prior art manual review process, but there is no mention of substantially real-time processing of requests for reimbursement to a point of service provider form a third party.

iii. Newswire does not Show or Suggest Substantially or Near Real-Time

The Examiner, in the Final Office Action, attempts to correct these deficiencies in Barber and Little by alleging that "Newswire discloses comprehensive software for real-time centralized benefit processing, claims editing, adjudication for benefit management organizations (see abstract). It would have been obvious to anyone of ordinary skill at the time of the invention to include the teachings of Newswire to the disclosure of Barber so that medical claims and bills processing is achieved in an efficient and expedited manner. Barber cites this as the primary goal of his system (Column 2, lines 32-33), so any addition that would move the claims processing closer to real-time would be ideal" (see Final Office Action, pp. 5-6).

Applicant has previously submitted (with the Office Action Response dated October 10, 2006) further references from the PHI website (the company discussed in the Newswire reference). Copies of these further references are also attached hereto as Exhibits A through N for convenience. These further references and Newswire are collectively referred to herein as "the PHI References." Applicants respectfully submit that when viewed in the proper context, the PHI References are non-analogous because the PHI References are focused on (1) enabling a corporate office to manage retail pharmacies and not providing reimbursement of a point of service provider in substantially real-time, and (2) reviewing operation of a retail pharmacy. None of the PHI References teaches a payment system.

The relied upon PHI References do not teach each and every limitation of the claimed "payment system" or the claim as a whole. Instead, the PHI References merely teach corporate oversight of retail pharmacies. In contrast, Applicant's claim 48, for example, requires a "payment system" that is "adapted to receive said substantially real-time adjudicated settlement transaction" and "in substantially real-time debit said payment system access card for said third party payment amount to be paid by said third party to reimburse said point of service provider

of said covered portion." Moreover, the reimbursement is in response to a point of service terminal "adapted to provide an indication of a purchase transaction in substantially real-time" to an "adjudication engine."

Applicant respectfully submits that the broad characterization that "any addition that would move the claims processing closer to real-time would be ideal" because the reasoning does not reflect Barber as a whole and does not address the notoriously well-known practice of insurance companies delaying payments to create a "float" of money for investment. In fact, Barber teaches delaying initiation of payment to a point of service provider for "a preselected number of days, e.g. 14 days," s*ee Barber* col. 7, ll. 53-56, which directly contradicts the cited rational to combine the reference and the manner of the combination.

Finally, as explained below, the Graham factors test strongly support non-obviousness.

(1) PHI References Are Non-Analogous Art and Do Not Teach a Substantially Real-Time Payment System.

(a) PHI References Are Non-Analogous

Applicants respectfully submit that the PHI References are non-analogous art and therefore not admissible to determine obviousness. Analogous art is that which is relevant to a consideration of obviousness under 35 O.S.C. § 103. *See Wang Laboratories, Inc. v. Toshiba Corp.*, 26 USPQ2d 1767, 1773 Fed. Cir. 1993) (*citing In re Sovish* , 769 F.2d 738, 741, 226 USPQ 771, 773 (Fed. Cir. 1985); *Panduit Corp. v. Dennison Mfg. Co.*, 810 F.2d 1561, 1568 n.9, 1 USPQ2d 1593, 1597 n.9 (Fed. Cir.), *cert. denied* , 481 U.S. 1052 (1987)).

To determine whether prior art is analogous, the court will consider: "(1) whether the art is from the same field of endeavor, regardless of the problem addressed, and (2) if the art is not within the same field of endeavor, whether it is still reasonably pertinent to the

particular problem to be solved." *See Wang* 26 USPQ2d at 1773 (*citing In re Clay*, 966 F.2d 656, 658-59, 23 USPQ2d 1058, 1060 (Fed. Cir. 1992)).

In *Wang*, the patents assigned to Wang Inc. disclosed a "Single In-Line Memory Module" (SIMM)

> "having eight data memory chips capable of storing 8-bit binary words or bytes...[and] a ninth chip, which functions as a check or parity bit for error detection. The nine memory chips, which are packaged in plastic leaded chip carriers (PLCCs), are mounted on a single epoxy glass printed circuit board substrate. Decoupling capacitors for suppressing voltage spikes are also mounted on the memory module substrate. Preferably, access terminals are arrayed across the bottom of the device for data input and output, data address and memory control, and device power."

See Wang, 26 USPQ2d at 1770.

The court held that an Allen-Bradley Co. patent for a "Memory Circuit for Programmable Machines", sold as an X9 SIMM, was non- analogous art. The court found that the prior art "disclose[d] a SIMM containing nine memory chips, eight for storing data and one for error detection, mounted in a single row" for use in a 9-bit industrial programmable controller. *See id.* at 1773. Similar to the Wang SIMM, the X9 SIMM "consisted of nine memory chips encapsulated in ceramic dual in-line packages (ceramic DIPs) mounted on an epoxy-glass printed circuit board substrate." *See id.* Yet, the court held that the X9 SIMM "is not in the same field of endeavor as the claimed subject matter merely because it relates to memories. It involves memory circuits in which modules of varying sizes may be added or replaced; in contrast, the subject patents teach compact modular memories." *See id.*

The court also found that the X9 SIMM was not reasonably pertinent to the … problem the Wang inventor attempted to solve. *See id.* "A reference is reasonably pertinent if, even though it may be in a different field from that of the inventor's endeavor, it is one which,

because of the matter with which it deals, logically would have commended itself to an inventor's attention in considering his problem." *See id.* The court found that the patented Wang SIMM was intended for use in Personal PCs while the X9 SIMM was intended for use in industrial controllers. Moreover, the Wang SIMM was implemented with the less expensive DRAM, which are primarily used in personal computers, while the prior art SIMMS are implemented with SRAM, which are larger and more expensive and not used in PCs. *See id.* Moreover, the prior art patent did not teach DRAMS. *See id.* As a result, the court held that prior art SIMM was "not analogous prior art [and] ... could not have rendered the claimed subject matter obvious." *See id.* at 1774.

Similar to *Wang*, the PHI References are non-analogous art relative to Applicant's disclosed invention because the PHI software is not in the same field of endeavor. The PHI References disclose pharmacy benefit management software providing a "retailer's solution for centralized management and control of all pharmacy transaction." *See* Exhibit I, PHI website: ProIntercept- Overview 2/17/1997; see also Exhibit H.

Providing a corporate manager a means to oversee and control a retail pharmacy operation is a substantially different endeavor from enabling a third party payer/ insurance company to initiate payment to a point of service provider in substantially real-time proximate to the time a beneficiary receives a service or good provide by a point of service provider. As a result, the PHI References are not in the same field of endeavor.

Similar to the prior art in *Wang*, which did not disclose DRAM, the PHI References disclose adjudication in the context of managing a corporate retail pharmacy company but not a payment system or creating a payment to a point of service provider relative to the time the product or service is provided. Instead, the PHI References focus on identifying corporate

manager oversight of a retail pharmacy organization to better manage each individual pharmacy. *See* Exhibits H and M. The cost, complexity and motivation of adjudicating an insurance claim for payment by a third party substantially in real-time involves issues and technical complexities neither addressed nor contemplated by the PHI software or any of the PHI References. As a result, the PHI References are non-analogous art because they are not reasonably pertinent to the problem being solved by the Applicant.

Applicants respectfully submit that the PHI References, when combined with the other prior art of record, do not show Applicants' claims would have been obvious to one of ordinary skill in the art.

(b) PHI References Do Not Teach or Suggest a Substantially Real-Time Payment System.

Applicants respectfully submit that the "PHI References" are limited in scope and do not enable one of ordinary skill in the art to appreciate Applicants' claims. Applicants submit that at most the PHI References teach providing information to corporate managers to allow corporate oversight and management of retail pharmacies.

(i) ***PHI References Merely Teach Providing Information to Allow Corporate Management of Retail Pharmacies.***

While the PHI Newswire marketing release arrogates "comprehensive software for real-time centralized benefit processing," one of ordinary skill in the art would have understood that the PHI software was a limited "retailer's solution for centralized management and control of pharmacy transaction." *See* Exhibit I. In other words, the PHI software claim editing and adjudication functions were part of a management tool for benefit management organizations to allow a manager to "obtain total centralized control of pharmacy providers and the resulting

prescription data." See Exhibit A. Even though the PHI software provides "direct communications interfaces to … third party administrators" of a pharmacy benefit management organization, the PHI References do not disclose or suggest a payment system or communications with a payment system.

Instead, the PHI software, as understood by those of ordinary skill in the art, only "provides the corporate office the ability to monitor and, if required, manipulate the inbound and outbound transactions of their retail locations." *See* Exhibit C. The PHI system does not disclose nor teach a payment system, connection to a payment system, nor a method of generating payments from a third party payer to third party provider that is substantially in real-time.

(ii) ***Scope of PHI References Limited to Managing Retail Pharmacies.***

Applicants respectfully submit that a secondary reference may not be used to change the fundamental characteristic of the primary reference. The PHI Newswire reference is used by the Examiner to broadly suggest "real-time processing." However, Barber is a batch processing system. As a result, the application of the PHI References to Barber is in appropriate. Thus, using the PHI References to impute a "real-time" characteristic to a third party payment system would fundamentally change the characteristic and teaching of Barber.

In fact, the PHI References do not disclose a payment system, much less a "real-time" third party payment system. Instead, the PHI References teach "benefit management organization" software to allow a corporate manager of large pharmacy company to oversee operation of retail pharmacies. *See* Exhibits H, I and M. As a result, one of ordinary skill in the art at the time of Applicant's invention would understand that the PHI References only disclose

software limited to providing managers information regarding "pharmacy transactions", *see* Exhibit H, and "monitor/manipulate…transactions from their retail locations." *See* Exhibit C.

The PHI software focuses on solving the problem of managing a large corporate retail pharmacy operation. In fact, the PHI References neither disclose, teach or suggest a real-time third party payment system nor address problems associated with generating a payment from a third party payment system. Instead, the PHI References focus on providing "centralized control and management of prescription data" in the context of managing a corporation composed of retail pharmacy operations. *See* Exhibit A. As a result, applying the PHI References to a payment system would not take into consideration either reference in their entirety and in the context of what one of ordinary skill in the art would have understood at the time of the invention.

Finally, Barber directly teaches delaying payment to a point of service provider. *See* Barber, col. 7, ll. 53-56 (teaching delaying claim adjudication /payment until "after a preselected number of days, e.g. fourteen days" after the goods or services are provided by the point of service provider). As a result, Applicant submits that the PHI Reference may not be used to modify the fundamental teaching of Barber, which is to provide a third party payment substantially later in time to providing the goods or service.

(2) <u>Graham Factors Weigh Heavy in Favor of Non-Obviousness</u>

Applicant respectfully submits that the secondary considerations as enunciated in *Graham v. John Deere* demonstrate Applicant's claims are non-obvious.

(a) Prior Art Teaches Away from Substantially in Real-time Payment by Third Party Payee to Point of Service Provider.

Applicant respectfully submits that the teaching of Barber related to generating payment to a point of service provider and the practice of floating funds support non-obviousness of Applicant's claims at issue.

Applicant respectfully submits that when considered as a whole and in the context of the prior art, Barber does not provide the required motivation to make the proposed combination. In fact, Barber expressly contradicts the reasoning to "include the teachings of PHI to the disclosure of Barber so that medical claims and bills processing is achieved in as efficient and expedited manner" because Barber teaches that "a funds transfers request" is generated only "after a preselected number of days, e.g. fourteen, the amounts covered by insurance on the prompt payment claims." *See* Barber, col. 7, ll. 53-56.

Moreover, Applicant respectfully submits that the well known practice of third-party payees floating funds to increase payee income directly teaches away from the proposed rational. As explicitly taught in Barber, see above, third party payers and insurance companies are notorious for delaying payment of accounts payable, and in particular, payments to point of service providers. In the insurance area, the "float" is the difference between received premiums and claims paid out. The insurer invests the "float" to produce income. While the proposed rational asserts that "any addition that would move the claims processing closer to real-time would be ideal," Applicant respectfully submits that Barber teaches that efficient adjudication is different than "timely" payment. Moreover, Barber teaches that even if efficiency is desirable, the goal of efficiency does not transfer into a desire to quickly generate payment by a third party payee to a point of service provider.

Indeed, Barber specifically and clearly teaches the practice and desire of delaying submission of claims for payment, which creates a float of funds. Applicants respectfully submit

that proposed rationale to combine the references is directly contradicted by Barber. In addition, Barber directly supports Applicants' arguments that the prior art teaches the desirability of floating funds. Taken together as a whole, Barber's explicit teaching and the practice of floating funds is substantial evidence that weighs heavily in favor of non-obviousness.

(b) Subsequent Adoption by Others supports non-obviousness.

Applicant respectfully submits that the Article "RealMed Launches Local Pilot in Indy," published October 12-18, 1998 in the Indianapolis Business Journal (see Exhibit P submitted with Applicants' Office Action Response filed October 10, 2006, attached hereto for convenience), stating RealMed had adopted a "card" containing "information about a person's health background, insurance plan and demographics" which is "designed to act like a debit card for insurance claims, resolving them at point of service," shows copying by others of Applicant's claimed invention. Copying by others supports a finding of non-obviousness. (RealMed Corp. is the current assignee of the present application because RealMed Corp. purchased the owner of the present application and its parents after the article in Exhibit P was published).

(c) Disbelief of Those of Ordinary Skill in the Art Shows No Reasonable Expectation of Success to Provide Substantially in Real-Time Payment.

The statement of Frank Goldstein, director of Summit Medical Group, as reported in USA Today on December 10, 1997, indicates a general disbelief that medical claims could result in a payment "to doctors in 48 hours" (See Exhibit O submitted with Applicants' Office Action Response filed October 10, 2006, attached hereto for convenience). In fact, the statement indicates disbelief that a payment system could act within two days, much less even approaching a "payment system adapted to debit a payment system access card" to provide payment to a point of service provider at the time of the purchase "in substantially real-time."

Applicant respectfully points to Mr. Goldstein's statement referring to potential payment to doctors within 48 hours, as shown in Exhibit O, that "I'll believe it when I see it" indicates strong and substantial disbelief that anyone could in fact provide a system to pay a service provider with 48 hours.

As a result, Mr. Goldstein's statements are strong evidence of non-obviousness directly supports a conclusion that there would not be a reasonable expectation of success to a system or method as taught by Applicant. As a result, Applicant's claims at issue would not have been obvious to one of ordinary skill in the art.

3. Specific Arguments: Claims 48-52, 54-56, 60-62, 67-71, 73-74, 78-79, 83, 87-90, 94, 95 and 96-98 are Allowable

Claim 48

As previously submitted and undisputed, the combination of Barber and Little teach neither real-time claims adjudication, processing, nor a payment system "adapted to in substantially real-time" provide a "third party payment amount to be paid by said third party to reimburse said point of service provider of said covered portion."

Applicant respectfully submits that claim 48 is non-obvious in view of Barber, in view of Little, and further in view of PHI References. First, as discussed above, the PHI References are non-analogous art. In other words, considered in context and as a whole, the PHI References only disclose providing information to corporate managers to enable oversight of a retail pharmacy, but do not teach or motivate a payment system or a payment system adapted to "debit a payment access card for said third party payment amount in substantially real-time" relative in time to receiving "said payment system access card for payment of a purchase of at least one of a

service and product." As a result, the PHI References may not be used to support a finding of obviousness.

Second, even if the PHI References are analogous art, Barber directly teaches away from the proposed combination. The broad interpretation that efficiency of claims processing implies expedited payment is directly contradicted by Barber's direct and unambiguous teaching of delaying claims by a "preselected number of days, e.g. fourteen days" from the time of purchase. Barber directly supports Applicants' argument that one skilled in the art recognizes the well known practice of "floating funds." As a result, the prior art teaches away from a payment system "adapted to in substantially real-time debit said payment system access card for said third party payment amount to be paid by said third party to reimburse said point of service provider of said covered portion." Thus, viewing Barber in its entirety, one of ordinary skill in the art would have viewed a motivation to improve efficiency of claims adjudicating processing as distinct and separate from any motivation to "debit" a "payment system access card" substantially in real-time.

Indeed, Barber directly teaches that even if the prior art taught a desire for more efficient claims adjudication, one of ordinary skill in the art would not be motivated to "move the claims process to real-time." Instead, Barber teaches that any motive or desire to improve adjudication efficiency is completely separate from a motive or desire to create a more efficient payment system for providing a third party payment. Thus, considering Barber in its entirety, Barber teaches that one of ordinary skill in the art would not make the proposed combination to modify the payments system, and the combination of Little and the PHI References do nothing to change this.

Finally, as discussed above, the Graham secondary factors substantially support non-obviousness. Considered as a whole, the Graham factors indicate the claims at issue would not have been obvious to one of ordinary skill in the art because the then art taught against "a payment system comprising a payment system network interface operably coupled to said network and adapted to receive said substantially real-time adjudicated settlement transaction, wherein said payment system is adapted to in substantially real-time debit said payment system access card for said third party payment amount to be paid by said third party to reimburse said point of service provider of said covered portion." Instead, the prior art taught that payment of a claim should be delayed to increase the float available to the third party payer. Moreover, the art expressed disbelief that a payment system could provide reimbursement even with 48 hours, much less substantially in real-time. As a result, one of ordinary skill in the art would have reasonably believed the proposed combination would likely fail.

Finally, Applicants respectfully submit that Barber, the practice of "floating funds" and the Graham factors do not support combining the PHI References with the other relied upon references. Instead, the opposite result is obtained. Considering Barber in its entirety, Barber and the notorious practice of floating funds directly teaches away from applying the PHI References or extending claims adjudication to any teaching related to a payment system.

As a result, Applicant respectfully submits that the burden of showing prima facie obviousness and that the Graham factors, when considered in the context of the prior art, substantially weigh in favor of non-obviousness. Hence, Applicant respectfully submits that claim 48 is in allowable form.

Claim 49

Applicant respectfully submits that prima facie obviousness is not established by the cited art because the cited art does not show "said point of service terminal is located in a pharmacy." While the Little reference disclose a "medical health care payment request adjudication method and apparatus" which includes using "historical payment request," defining "master list of payable payment request", and codifies "a set of interpretive rules" that are related to "patient and health care," the Little reference does not disclose a "point of service terminal is located at a pharmacy." In addition, Little does not teach placing the "adjudication apparatus" at a pharmacy.

While Barber teaches "physician terminals" located in "a physician's office," Barber does not teach locating a "physician terminal" at a pharmacy. The cited references do not show placement of "physician terminals" in a separate pharmacy or an HMO pharmacy. The references do not provide any description of the manner in which prescriptions are filled in the HMO environment. In addition, even assuming that "specifically large HMO's have a pharmacy on the premises," the references do not show nor is a rational provided to explain how a purchase of a service or a product at an HMO pharmacy located at the same premises as a doctor's office would involve "at least part of said purchase" being "reimbursable by a third party."

Moreover, the prior art does not show a "point of network interface coupled to a network and adapted to provide an indication of a purchase transaction in substantially real-time and a card interface adapted to receive said payment access card for payment of a purchase of at least on of a service or product... wherein at least part of said purchase is reimbursable by a third party" located at a pharmacy.

Finally, because claim 49 depends from claim 48, claim 49 is allowable to the extent that claim 48 is allowable.

Claim 50

While Barber discloses "physician terminals" located at a physician's office, Barber does not disclose "a point of service terminal operably coupled to said network and adapted to provide an indication of a purchase transaction substantially in real-time" or "debiting said payment system access card" substantially in real-time. Instead, Barber teaches that "after a preselected number of days, e.g. fourteen, the amounts covered by insurance on the prompt payment claims are organized by physician and a report generated to create a funds transfer request." *See* Barber, col. 7, ll. 53-57. As a result, the "physician terminal" disclosed in Barber does not teach nor disclose the claimed invention as a whole, and the combination of Little and the PHI References do nothing to correct this defficiency.

Otherwise, Applicants respectfully submit that claim 50 depends from claim 48 and is allowable to the extent claim 48 is allowable.

Claim 51-55

Applicants respectfully submit that claims 51-55 depend from claim 48 and are allowable to the extent claim 48 is allowable.

Claim 56

Applicants respectfully submit that while Barber discloses a remote terminal including a card reader capable of reading "patient identification cards" or "credits cards", Barber does not disclose nor teach all the limitations of claim 56. Claim 56 requires a "payment system access card comprising an identification of a beneficiary and financial card information." The combination of Little and the PHI References do nothing to correct this defficiency. As a result, Applicant respectfully submits that the prior art fails to meet the burden for showing prima facie obviousness because the cited prior art does not show each and every element and limitation. In

addition, the Graham factor's analysis shows adoption of the combination after Applicants' filing date, which is evidence of non-obviousness.

Otherwise, Applicants respectfully submit that claim 56 depends from claim 48 and is therefore allowable if claim 48 is allowable.

Claims 60-62, 67, 69-71, 73-74

The Examiner rejected these claims as "obvious to perform in light of previously rejected system claims 48-52, 55 and 56 respectively and are therefore rejected using the same art and rationale" (see Final Office Action, p. 8). Applicants therefore respectfully submit that claims 60-62 are allowable in view of the references of record for the same reasons set forth above with respect to claims 48-52, 55 and 56.

Claim 78

While Barber, Col. 2, ll.21-25 discloses a "centralized processing means including a funds transfer means for transferring funds collected from the insurance carrier directly to a bank account of the appropriate physician," Barber also teaches delaying payment of claims substantially after the service is provided. *See* Barber, col. 7, ll. 53-56 (teaching delaying funds transfer until "after a preselected number of days, e.g. fourteen days.") Yet, claim 78 requires "transferring funds to a point of service provider account substantially in real-time relative to the receipt of said adjudicated transaction in accordance with said adjudicated transaction to said point of service."

Applicants respectfully submit that the references provide neither a specific rational for combining cited references nor every limitation of the claim as a whole. As discussed at length above, the Barber reference provides no motivation to combine the PHI References teaching relative to "transferring funds." In addition, as discussed above, the Graham factors strongly

favor non-obviousness because Barber and the well known practice of floating funds strongly teach away from the limitations of claim 78 and the disbelief of those of ordinary skill in the art show that there would not have been a reasonable expectation of success that the proposed combination would have worked. As a result, Applicants respectfully submit that claim 78 is non-obvious because the prior art does not teach each limitation present in the claim at issue, the prior art provides no motivation to combine the references, and the Graham secondary consideration strongly favor non-obviousness.

Finally, Applicants respectfully submit that claim 78 depends from claim 67 and is therefore allowable if claim 67 is allowable.

Claim 79

The Examiner rejected claim 79 as "obvious in order to implement the previously rejected method claim 60 in the previously rejected system and is therefore rejected using the same art and rationale" (see Final Office Action, p. 9). Applicants therefore respectfully submit that claim 79 is allowable in view of the references of record for the same reasons set forth above with respect to claim 60.

Claim 83

The Examiner rejected claim 83 as "obvious in order to implement the previously rejected system claim 48 and is therefore rejected using the same art and rationale" (see Final Office Action, p. 9). Applicants therefore respectfully submit that claim 83 is allowable in view of the references of record for the same reasons set forth above with respect to claim 48.

Claim 87

Claim 87 specifically requires "said adjudication engine is adapted to provide said adjudicated settlement transaction substantially at the time of said purchase" and "a payment

system . . . [to] initiate reimbursement of said third party payment amount to said service provider substantially at the time of said purchase transaction." As discussed hereinabove with respect to claim 48, the prior art, when taken alone or in combination, does not show or suggest these aspects of Applicants' claim 87.

Claim 88

The Examiner rejected claim 88 as "obvious from previously rejected claim 49, and therefore is rejected using the same art and rationale" (see Final Office Action, p. 9). Applicants therefore respectfully submit that claim 88 is allowable in view of the references of record for the same reasons set forth above with respect to claim 49.

Claim 89

Claim 89 depends from claim 87 and therefore includes all of the limitations of claim 87. It is therefore respectfully submitted that claim 89 is allowable over the references of record for the same reasons set forth above with respect to claim 87.

Claim 90

The Examiner rejected claim 90 saying "Barber/Little/Newswire discloses the claimed system supra, system claims 48-52, 55 and 56 respectively and are therefore rejected using the same art and rationale" (see Final Office Action, pp. 9-10). Applicants therefore respectfully submit that claim 90 is allowable in view of the references of record for the same reasons set forth above with respect to claims 48-52, 55 and 56.

Claim 94

Claim 94 depends from claim 87 and therefore includes all of the limitations of claim 87. It is therefore respectfully submitted that claim 94 is allowable over the references of record for the same reasons set forth above with respect to claim 87.

Claim 95

The Examiner rejected claim 95 as "obvious in view of previously rejected claim 56, and is therefore rejected using the same art and rationale" (see Final Office Action, p. 10). Applicants therefore respectfully submit that claim 95 is allowable in view of the references of record for the same reasons set forth above with respect to claim 56.

Claims 96-98

The Examiner rejected claims 96-98 as "obvious in order to perform previously rejected claims 57-59, and is therefore rejected using the same art and rationale" (see Final Office Action, p. 10). Applicants therefore respectfully submit that claims 96-98 are allowable in view of the references of record for the same reasons set forth above with respect to claims 57-59.

D. CLAIMS 53, 57-59, 63-66, 72, 75-77, 80-82, 84-86, 91 AND 99-111 ARE ALLOWABLE UNDER 35 U.S.C. §103 OVER BARBER ET AL, IN VIEW OF LITTLE ET AL. AND FURTHER IN VIEW OF NEWSWIRE AND FURTHER IN VIEW OF SACKLER ET AL.

1. CLAIMS 53, 57-59, 63-66, 72, 75-77, 80-82, 84-86, 91 and 99-111 ARE NON-OBVIOUS IN VIEW OF CITED ART.

Claims 53, 57-59, 63-66, 72, 75-77, 80-82, 84-86, 91 and 99-111 "were rejected under 35 U.S.C. 103(a) as being un-patentable over Barber in view of Little in view of Newswire as applied to claim 48 above, and in further view of Sackler et al." Applicants respectfully submit that the rejection of claims 53, 57-59, 63-66, 72, 75-77, 80-82, 84-86, 91 and 99-111 relies upon a combination of four separate references, none of which teach, suggest, enable or motivate one skilled in the art to combine a "real-time", "near-real-time", "substantially real-time", or

"approximately real-time" characteristic to a payment system. In fact, as discussed above, Barber specifically and directly teaches away from the proposed combination.

Applicants respectfully submit that the burden to show prima facie obviousness requires each claim at issue to be considered as a whole to determine whether the claim would have been obvious to one skilled in the art. In addition, the prior art must be considered in its entirety and not merely as a mosaic of elements that may be combined. Thus, the totality of the rational used to justify including each incremental teaching weighs against the proposed combination because an inference upon an inference is an insufficient basis for a rejection.

Claim 53

Claim 53 depends from claim 48 and therefore includes all of the limitations of claim 48. It is therefore respectfully submitted that claim 53 is allowable over the references of record for the same reasons set forth above with respect to claim 48.

Claim 57

While Sackler states a "means for calculating the payment required by the claimant," Sackler does not teach or suggest calculating "a non-covered portion that is to be paid by the one of a beneficiary and a customer" as part of a "substantially real-time adjudicated settlement transaction."

Otherwise, Applicant respectfully submits that because claim 57 depends from claim 48, claim 57 is allowable to the extent the claim 48 is allowable.

Claim 58

While Sackler discloses "directly charging a patent's account," for the non-covered amount, Sackler does not teach or disclose "said payment system charges said payment access card for said non-covered amount." Moreover, Applicant respectfully submits that neither Sackler nor PHI teach the limitation of "substantially real-time adjudication settlement" wherein "said payment system charges said payment access card for said non-covered amount."

Otherwise, Applicant respectfully submits that because claim 58 depends from claim 48, claim 58 is allowable to the extent the claim 48 is allowable.

Claim 59

Claim 59 depends from claim 48 and therefore includes all of the limitations of claim 48. It is therefore respectfully submitted that claim 59 is allowable over the references of record for the same reasons set forth above with respect to claim 48.

Claims 63-66

The Examiner rejected claims 63-66 as "obvious in order to perform previously rejected claims 56-59, and are therefore rejected using the same art and rationale" (see Final Office Action, p. 12). Applicants therefore respectfully submit that claims 63-66 are allowable in view of the references of record for the same reasons set forth above with respect to claims 56-59.

Claims 72 and 75-77

The Examiner rejected claims 63-66 as "obvious in order to perform previously rejected claims 53 and 57-59, and are therefore rejected using the same art and rationale" (see Final Office Action, p. 12). Applicants therefore respectfully submit that claims 72 and 75-77 are allowable in view of the references of record for the same reasons set forth above with respect to claims 53 and 57-59.

Claims 80-82

The Examiner rejected claims 80-82 as "obvious in order to implement the previously rejected method claims 57, 59 and 53 respectively in the previously rejected system and is therefore rejected using the same art and rationale" (see Final Office Action, pp. 12-13). Applicants therefore respectfully submit that claims 80-82 are allowable in view of the references of record for the same reasons set forth above with respect to claims 57, 59 and 53.

Claims 84-86

The Examiner rejected claims 84-86 as "obvious to implement from previously rejected system claims 57-59 and are therefore rejected using the same art and rationale" (see Final Office Action, p. 13). Applicants therefore respectfully submit that claims 84-86 are allowable in view of the references of record for the same reasons set forth above with respect to claims 57-59.

Claim 90

The Examiner rejected claim 90 as "obvious to implement from previously rejected system claims 48, 57, and 58 and are therefore rejected using the same art and rationale" (see Final Office Action, p. 13). Applicants therefore respectfully submit that claim 90 is allowable in view of the references of record for the same reasons set forth above with respect to claims 48, 57, and 58.

Claim 99

The Examiner rejected claim 99 as "obvious in order to perform previously rejected system claims 60, 67, 74, 78, 79, and 87 respectively and are therefore rejected using the same art and rationale" (see Final Office Action, p. 13). Applicants therefore respectfully submit that

claim 99 is allowable in view of the references of record for the same reasons set forth above with respect to claims 60, 67, 74, 78, 79, and 87.

Claims 100-103

Claims 100-103 depend from claim 99 and therefore include all of the limitations of claim 99. It is therefore respectfully submitted that claims 100-103 are allowable over the references of record for the same reasons set forth above with respect to claim 99.

Claim 104

The Examiner rejected claim 104 as "the method would have been obvious in view of previously rejected claims 100 and 101 and therefore is rejected using the same art and rationale" (see Final Office Action, p. 14). Applicants therefore respectfully submit that claim 104 is allowable in view of the references of record for the same reasons set forth above with respect to claims 100 and 101.

Claims 105-110

Claims 105-110 depend from claim 99 and therefore include all of the limitations of claim 99. It is therefore respectfully submitted that claims 105-110 are allowable over the references of record for the same reasons set forth above with respect to claim 99.

Claim 111

The Examiner rejected claim 111 as "the method would have been obvious in view of previously rejected claims 60, 67, 74, 78, 79, and 87 and therefore is rejected here under the same art and rationale" (see Final Office Action, p. 15). Applicants therefore respectfully submit that claim 111 is allowable in view of the references of record for the same reasons set forth above with respect to claims 60, 67, 74, 78, 79, and 87.

VIII. APPENDIX OF CLAIMS

(37 CFR § 41.37(c)(viii))

The text of the claims involved in the appeal are:

48. A system for debiting a payment system access card to provide substantially near real-time reimbursement to a point of service provider by a third party comprising:

a network;

a point of service terminal comprising a point of service terminal network interface operably coupled to said network and adapted to provide an indication of a purchase transaction in substantially real-time and a card interface adapted to receive said payment system access card for payment of a purchase of at least one of a service and product to said point of service provider, wherein at least part of said purchase is reimbursable by a third party;

an adjudication engine comprising an adjudication engine network interface operably coupled to said network and adapted to receive said indication of said purchase transaction and produce a substantially real-time adjudicated settlement transaction comprising an indication of a third party payment amount for at least one of medical services or products;

a payment system comprising a payment system network interface operably coupled to said network and adapted to receive said substantially real-time adjudicated settlement transaction, wherein said payment system is adapted to in substantially real-time debit, said payment system access card for said third party payment amount to be paid by said third party to reimburse said point of service provider of said covered portion.

49. The system of claim 48, wherein said point of service terminal is located in a pharmacy.

50. The system of claim 48, wherein the point of service terminal is located in a physician office.

51. The system of claim 48, wherein said payment system is further adapted to initiate a funds transfer from at least a first account and a second account, wherein said second account is designated by a beneficiary of said third party payer.

52. The system of claim 48, wherein said purchase transaction comprises at least one service code which said adjudication engine compares to payment parameters and conditions from the third party to determine the value of said covered portion of said purchase to be paid by the third party.

53. The system of claim 48, wherein said purchase transaction comprises at least one co-payment amount.

54. The system of claim 48, wherein said network comprises at least one Internet connection.

55. The system of claim 48, wherein said adjudication engine comprises a data driven rules engine comprising an interface for at least one of receiving and processing data from a customer, said point of service provider, said third party, to determine the covered portion of the payment to be paid by the third party.

56. The system of claim 48, wherein said payment system access card comprises beneficiary and financial card information;

wherein said payment system is further adapted to provide a settlement transaction to be received by a financial network.

57. The system of claim 48, wherein said adjudication engine calculates a non-covered portion that is to be paid by the one of a beneficiary and a customer.

58. The system of claim 57, wherein said payment system charges said payment system access card for said non-covered portion that is to be paid by said one of a beneficiary and said customer to pay said service provider said non-covered portion.

59. The system of claim 57, wherein said payment system charges a personal credit card of said one of said beneficiary and said customer for said non-covered portion that is to be paid by the customer.

60. A method for providing reimbursement to a service provider by a third party in substantially real-time comprising the steps of:

receiving a payment system access card at said point of service provider for payment of a purchase of at least one of a service and product by a customer, at least part of said purchase being reimbursable by said third party;

transmitting a purchase transaction in substantially real-time to an adjudication engine for processing, wherein said adjudication engine adjudicates said purchase transaction in substantially real-time to produce an adjudicated transaction comprising a covered portion of said purchase that is to be paid by the third party;

receiving an adjudicated transaction in substantially real-time comprising an indication of said covered portion to be paid by said third party; and

debiting said access card substantially in real-time for said covered portion that is to be paid by said third party.

61. The method of claim 60, wherein the point of service provider is a pharmacy.

62. The method of claim 60, wherein the point of service provider is a physician.

63. The method of claim 60, wherein said adjudicated transaction further comprises an indication of a non-covered portion.

64. The method of claim 63 further comprising the step of:

providing an indication of said non-covered portion to one of a financial card network as an adjudicated transaction formatted as a financial card transaction.

65. The method of claim 64 wherein said payment system access card comprises a finance card and a personal identification.

66. The method of claim 65, wherein said finance card is adapted to interface with a credit card network.

67. A method for providing payment to a point of service provider from a third party in substantially real-time comprising the steps of:

providing a payment system to receive a purchase transaction from said point of service provider, wherein said purchase transaction is generated at least in part by a purchase of least one of a service and a product by one of a customer, insured or beneficiary, at least part of said purchase being reimbursable by said third party;

receiving said purchase transaction from a point of service provider;

adjudicating said purchase transaction to produce an adjudicated transaction including a covered portion of said purchase to be paid by said third party;

transmitting an indication of said covered portion of said purchase to be paid by said third party to said point of service provider in substantially real-time,

producing a transfer funds indication in accordance with said adjudicated transaction wherein said payment system access card is debited for said covered portion that is to be paid by said third party and said point of service provider is reimbursed for said covered portion, wherein said transfer funds indication is received by said point of service provider at the time of said purchase; and

initiating a transfer of funds from said at least one account associated with said one of a customer, insured or beneficiary, wherein said transfer of funds is initiated at the time of said purchase.

68. The method of claim 67, wherein the point of service provider is a retail pharmacy and said transfer funds indication is received at said retail pharmacy.

69. The method of claim 67, wherein the point of service provider is a physician and said transfer funds indication is received by said physician.

70. The method of claim 67, wherein said purchase transaction includes at least one product identifier, the method further comprising the step of:

said adjudication engine comparing said at least one product identifier to payment parameters and conditions to determine the value of said covered portion of said purchase to be reimbursed by said third party.

71. The method of claim 67, further comprising the step of:

debiting at least a first account and a second account, wherein said second account is designated by a beneficiary of said third party payer.

72. The method of claim 71, wherein said purchase comprises at least one co-payment amount.

73. The method of claim 71, wherein said adjudication engine operably couples to an Internet connection and said point of service terminal accesses said adjudication engine via said Internet connection.

74. The method of claim 71, wherein said payment system access card comprises a financial card, and said payment system operably couples to a financial card network, the method further comprising the step of:

providing in substantially real-time an adjudicated settlement transaction formatted as a financial card transaction for said financial card network.

75. The method of claim 71 comprising the further step of:

calculating a non-covered portion to be paid by the customer;

providing an indication of said non-covered portion to one of a financial card network to reimburse said point of service provider for said non-covered portion.

76. The method of claim 75 comprising the further step of:

charging said payment system access card for said non-covered portion to be paid by the customer.

77. The method of claim 76 comprising the further step of:

charging a credit card for said non-covered portion.

78. The method of claim 67 further comprising the step of:

transferring funds to a point of service provider account substantially in real-time proximate to the receipt of said adjudicated transaction in accordance with said adjudicated transaction to said point of service.

79. A computer data signal embodied in a carrier wave to provide a third party payment to a point of service provider comprising:

a third party payment amount due from a third party benefit provider to a point of service provider for payment of at least one of a medical service or product provided to one of a beneficiary and a customer;

wherein said computer data signal is provided in approximately real-time by a payment system operably coupled to a network in response to receiving an indication of a purchase transaction from a point of service provider for a healthcare related service or product; and wherein said data computer signal is produced by said payment system to initiate a payment from a third part payer account to said point of service provider at the time of purchase.

80. The computer data signal of claim 79 further comprising:

an indication of a non-covered payment amount.

81. The computer data signal of claim 80, wherein said indication of a non-covered payment amount is adapted to be received by a financial card transaction network.

82. The computer data signal of claim 80, wherein at least a portion of said indication of a non-covered payment amount is a co-payment.

83. A point of service terminal method comprising the steps of:

receiving a computer data signal embodied in a carrier wave comprising: a third party payment amount due from a third party to a point of service provider for payment of at least one of a medical service or product provided to a customer;

debiting a payment system access card for said third party payment amount in response to said computer data signal at the time of said purchase.

84. The point of service terminal of claim 83 further comprising the step of:

providing an indication of said non-covered payment amount to be paid by said customer.

85. The point of service terminal of claim 84 further comprising the step of:

generating a financial card transaction to receive payment of said non-covered payment amount to be paid by said customer.

86. The point of service terminal of claim 83 wherein said computer date signal embodied in a carrier wave further comprises an indication of a non-covered payment, the point of service terminal further comprising the step of:

debiting said payment access car for said non-covered payment.

87. A system comprising:

an adjudication engine operably coupled to a network, said adjudication engine adapted to receive an indication of a purchase transaction generated at the time of a purchase of one of a health care service or product from a point of service provider and beneficiary payment system access information, wherein at least part of said purchase is payable by a third party; and said

adjudication engine is further adapted to provide a substantially real-time adjudicated settlement transaction; wherein said adjudication engine is adapted to provide said adjudicated settlement transaction substantially at the time of said purchase;

a payment system comprising a payment system network interface operably coupled to a financial network and said adjudication engine, said payment system adapted to receive said adjudicated settlement transaction and in response to initiate reimbursement of said third party payment amount to said service provider substantially at the time of said purchase transaction, and including a messaging system adapted to provide a receipt to said point of service provider corresponding to said initiated reimbursement.

88. The system of claim 87, wherein said purchase transaction is generated as a result of a retail pharmacy purchase transaction.

89. The system of claim 87, wherein the purchase transaction is generated as a result of a purchase transaction at a physician's office.

90. The system of claim 87, wherein said payment includes a first portion from a first account and a second portion from a second account.

91. The system of claim 90, wherein at least a portion of said payment is from a beneficiary designated account.

92. The system of claim 90, wherein at least a portion of said payment is from a pre-funded account.

93. The system of claim 87, wherein at least a portion of said reimbursement is from a first third party payer and a second portion is from a second third party payer.

94. The system of claim 87, wherein said payment system further comprises a messaging system adapted to provide said point of service provider a receipt corresponding to said adjudicated settlement transaction.

95. The system of claim 87, wherein said payment system access card comprises a beneficiary and financial card information, wherein said payment system further comprises an adjudicated settlement transaction adapted to be received by a financial network.

96. The system of claim 87, wherein said adjudication engine is adapted to calculate a non-covered portion that is to be paid by the one of a beneficiary and a customer.

97. The system of claim 96, wherein said payment system charges a payment system access card for said non-covered portion that is to be paid by said one of a beneficiary and said customer to pay said service provider said non-covered portion.

98. The system of claim 96, wherein said payment system charges a personal credit card of said one of said beneficiary and said customer for said non-covered portion that is to be paid by the customer.

99. A method for providing payment to a point of service provider comprising the steps of:

receiving at a payment system an adjudicated purchase transaction generated in response to a purchase transaction at a point of service provider at the time of a purchase, wherein said adjudicated purchase transaction is for at least in part a good or service provided to a beneficiary of said third party benefit provider from said point of service provider;

initiating a funds transfer from at least one account in accordance with said adjudicated transaction wherein said payment system provides payment of at least a covered portion from an account accessible administered by said third party;

wherein said funds transfer for said covered portion is initiated substantially in real-time to the purchase of said good or service from said point of service provider.

100. The method of claim 99, wherein said account is accessible to said third party beneficiary.

101. The method of claim 100, wherein said account is owned by said third party beneficiary.

102. The method of claim100, wherein said account is designated by said beneficiary for payment of health related goods or services.

103. The method of claim 99, wherein said account is designated by said beneficiary for payment of health related goods or services.

104. The method of claim 99, wherein said at least one account comprises a first third party account and at least one third party beneficiary designated account.

105. The method of claim 99 further comprising the step of:

providing an account summary of purchase transactions to said beneficiary via a web page.

106. The method of claim 99 further comprising the step of:

providing a receipt to said point of service provider corresponding to said adjudicated purchase transaction, wherein said receipt is provided to said point of service provider via a network at the time of said purchase.

107. The method of claim 106, wherein said receipt is provided by said payment system.

108. The method of claim 99, further comprising the step of providing a receipt corresponding to said initiated funds transfer at the time of said purchase transaction, wherein said receipt is provided to said point of service provider via a network substantially at the time of said purchase.

109. The method of claim 108, wherein said receipt is provided by said payment system.

110. The method of claim 99 further comprising the step of providing a message to said point of service provider in response to said adjudicated purchase transaction, wherein said receipt arrives at said point of service provider substantially at the time said point of service provider provides said service or good.

111. The method of claim 99, further comprising the steps of:

receiving a purchase transaction from said point of service provider for providing at least in part a good or service provided to said beneficiary;

producing an adjudicated purchase transaction substantially in real-time;

sending said adjudication purchase transaction to said payment system substantially at the time of said purchase.

IX. APPENDIX OF EVIDENCE

(37 CFR § 41.37(c)(ix))

Exhibits A-P containing prior art not cited by the Examiner. Entered into the record on 10/10/06 when submitted by Applicants in support of their Response to Office Action.

X. APPENDIX OF RELATED DECISIONS

(37 CFR § 41.37(c)(x))

None.

Respectfully Submitted:

/troy j. cole/

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PHI ProPBM - Executive Summary

EXHIBIT A

EXECUTIVE SUMMARY

The pharmacy benefit management (PBM) industry has matured in its use of previously developed computer hardware and software applications. Increasingly complex payer requirements relative to benefit design and new challenges for information access have caused pharmacy benefit management organizations to review their existing system capabilities.

Pharmacy providers have evolved in the use of more sophisticated point of sale computer systems. Similarly, PBM's are finding it necessary to upgrade their own systems in order to keep pace with the industry and take advantage of opportunities associated with the control and management of prescription data.

Today, PBM's are demanding software solutions which will allow them to obtain total centralized control of pharmacy providers and the resulting prescription data, so as to provide both cost savings and a higher level of patient care. The Prospective Health system is that solution.

PBM legacy systems are often designed around aging technology and are typically deficient in a number of areas, including:

- Benefit design flexibility
- Effective formulary control
- Edit capabilities
- Drug Utilization Review
- Provider audit capability
- Cognitive Services tracking
- Payer/Provider reporting
- Advanced Pharmacy/Physician Networking
- Client/Server Architechture
- Intuitive user interface

ProPBM effectively addresses these issues. On the following pages you will find an overview of the ***ProPBM*** system capabilities. We encourage you to examine this in detail and to contact us for a demonstration of the system. Thank you for your interest in PHI.

Last Updated: 02/06/98

EXHIBIT B

PHI - Development Approach

Given the pace of technological change in today's business environment, more and more companies are finding it difficult to keep their systems flexible enough to meet the demands of their business and their customers. As the pharmacy industry experiences these technological shifts, many companies need to update the legacy systems that have been in place for years. PHI provides a solution to these problems.

Using the latest database technology, along with client/server architecture and object oriented programming, the PHI ***ProPBM*** system provides a complete solution for pharmacy benefit management organizations. Unlike legacy systems, the PHI system is designed to be easily maintained. ***ProPBM*** is made up of various components which can be easily modified and then "plugged" back into the system with few or no changes to the core system. This allows new features to be added when they can still help generate new business or retain existing customers.

With the ever-changing pharmacy benefit market, it is important that a system be flexible; but, it's also important that the company developing the system understands the market and be able to move aggressively to meet the needs of its customers. PHI knows this and works very closely with our clients. Through initial discussions and demonstrations, installation and training, PHI is there every step of the way. After installation and training is complete, PHI works with clients to ensure that all components are optimized to meet or exceed expected performance. We understand that our biggest commitment to the customer is after the sale.

Development Highlights:

- Mulit-Platform
- Client/Server Architecture
- Graphical Interface
- Relational Database Technology
- Scalable
- Data Mining capabilities
- Designed for high volume OLTP
- Decision Support Database

All PHI systems follow defined NCPDP industry standards.

Last Updated: 02/06/98

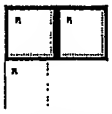
EXHIBIT C

PHI ProINTERCEPT

ProINTERCEPT was developed to enhance the financial returns for retail chains on their third party prescription transactions. The system provides the corporate office the ability to monitor and, if required, manipulate the inbound and outbound transactions from their retail pharmacy locations.

Please feel free to take a tour of our online system description.

- PHI ProINTERCEPT - Executive SummaryNew!Hot!
- PHI - Development Approach
- ProINTERCEPT - Overview



Last Updated: 02/10/97

EXHIBIT D

ProPBM Functional Modules

• **Member Eligibilty** - provides complete functionality for maintaining membership data. The system accepts a variety of input, including tape, disk and electronic.

• **Helpdesk** - The helpdesk facility allows authorized users to examine a prescription transaction at the lowest detail level. In addition, authorized users have access to plan and membership information, physician pharmacy network, drug master file and formulary information all within the same system, only a mouse click away. Authorization can be view only or the user may have edit capabilities if needed.

• **Plan Edits** - The plan edits module truly showcases the flexibility of the ***ProPBM*** system. Many components can be copied and reused to create other plans. This applies to price schedules, copay schedules, networks and all levels of drug edits (drug class, therapy class, GPI and NDC).

• **Reporting (ProANALYST)** - In addition to the multiple standard reports the system provides, ***ProANALYST*** allows the user to create custom reports quickly with no programming involved.

• **Switch (ProNET)** - The ***ProNET*** communication application handles point-of-service prescription transactions in the NCPDP standard 3.2 format from any software in place at pharmacies. Support of multiple communication protocols provides access through all major common carriers.

Last Updated: 02/06/98

EXHIBIT E

PHI - Development Approach

Given the pace of technological change in today?s business environment, more and more companies are finding it difficult to keep their systems flexible enough to meet the demands of their business and their customers. As the pharmacy industry experiences these technological shifts, many companies need to update the legacy systems that have been in place for years. PHI provides a solution to these problems.

Using the latest database technology, along with client/server architecture and object oriented programming, the PHI ***ProINTERCEPT*** system provides a complete solution for retail pharmacy chains. Unlike legacy systems, the PHI system is designed to be easily maintained. ***ProINTERCEPT*** is made up of various components which can be easily modified and then "plugged" back into the system with few or no changes to the core system. This allows new features to be added when they can still help generate new business or retain existing customers.

With the ever changing retail pharmacy market, it is important that a system be flexible; but, it?s also important that the company developing the system understands the market and be able to move aggressively to meet the needs of its customers. PHI meets this need and works very closely with our clients. Through initial discussions and demonstrations, installation and training, PHI is there every step of the way. After installation and training is complete, PHI works with clients to ensure that all components are optimized to meet or exceed expected performance. We understand that our biggest commitment to the customer is after the sale.

Development Highlights:

- Multi-Platform.
- Client/Server Architechture.
- Graphical Interface.
- Relational Database Technology.
- Scalable.
- Data Mining Capabilities.
- Designed for high volume OLTP.
- Decision Support Database.

All PHI systems follow defined NCPDP industry standards!

Last Updated: 02/10/97

PHI - Development Approach

EXHIBIT F

Given the pace of technological change in today?s business environment, more and more companies are finding it difficult to keep their systems flexible enough to meet the demands of their business and their customers. As the pharmacy industry experiences these technological shifts, many companies need to update the legacy systems that have been in place for years. PHI provides a solution to these problems.

Using the latest database technology, along with client/server architecture and object oriented programming, the PHI ***ProPBM*** system provides a complete solution for pharmacy benefit management organizations. Unlike legacy systems, the PHI system is designed to be easily maintained. ***ProPBM*** is made up of various components which can be easily modified and then "plugged" back into the system with few or no changes to the core system. This allows new features to be added when they can still help generate new business or retain existing customers.

With the ever-changing pharmacy benefit market, it is important that a system be flexible; but, it?s also important that the company developing the system understands the market and be able to move aggressively to meet the needs of its customers. PHI knows this and works very closely with our clients. Through initial discussions and demonstrations, installation and training, PHI is there every step of the way. After installation and training is complete, PHI works with clients to ensure that all components are optimized to meet or exceed expected performance. We understand that our biggest commitment to the customer is after the sale.

Development Highlights

- Mulit-Platform.
- Client/Server Architecture.
- Graphical Interface.
- Relational Database Technology.
- Scalable.
- Data Mining capabilities.
- Designed for high volume OLTP.
- Decision Support Database.

All PHI systems follow defined NCPDP industry standards!

Last Updated: 02/10/97

EXHIBIT G

ProPBM Functional Modules

- **Member Eligibilty** - provides complete functionality for maintaining membership data. The system accepts a variety of input, including tape, disk and electronic.

- **HelpDesk (ProHELPDESK)** - The helpdesk facility allows authorized users to examine a prescription transaction at the lowest detail level. In addition, authorized users have access to plan and membership information, physician pharmacy network, drug master file and formulary information all within the same system, only a mouse click away. Authorization can be view only or the user may have edit capabilities if needed.

- **Plan Edits** - The plan edits module truly showcases the flexibility of the<*B*> *ProPBM* system. Many components can be copied and reused to create other plans. This applies to price schedules, copay schedules, networks and all levels of drug edits (drug class, therapy class, GPI and NDC)..

- **Reporting (ProANALYST)** - In addition to the 100+ standard reports the system provides, *ProANALYST* allows the user to create custom reports quickly with no programming involved.

- **Switch (ProNET)** - The *ProNET* communication application handles point-of-service prescription transactions in the NCPDP standard 3.2 format from any software in place at pharmacies. Support of multiple communication protocols provides access through all major common carriers.

Last Updated: 02/10/97

EXHIBIT H

PHI ProPBM

ProPBM is the most advanced Pharmacy Benefit Management System available today. Using the latest client/server technology, ***ProPBM*** provides a stable, scalable solution for today's Pharmacy PBM.

Please take a minute to review some more details about the PHI ***ProPBM*** system.

- PHI ProPBM - Executive SummaryNew!Hot!
- ProPBM - Overview
- ProPBM Functional Modules
- PHI - Development Approach

Last Updated: 02/13/97

ProINTERCEPT - Overview

EXHIBIT I

ProINTERCEPT is the retailer's solution for centralized management and control of all pharmacy transactions. This includes all cash and third party prescriptions.

ProIntercept - Key Features Hot!

- Transmission of messages form a virtually unlimited number of retail stores to corporate offices.
- On-line, real-time analysis, capture and disposition of every prescription transaction.
- Direct communications interfaces to every major third party administrator.
- Prospective audits of pharmacist dispensing decisions.
- Prospective audits of third party administrators adjudication decisions.
- Retrospective analysis of all data collected to provide:
  - *Reconciliation of payment for third party prescriptions.*
  - *Centralized inventory controls via custom interfaces with each client's purchasing and distribution systems.*
  - *Pharmacy Dispensing Patterns review.*
  - *Cognitive Services documentation.*

ProNET, the system?s switch module, handles point-of-service prescription transactions in the NCPDP's standard 3.2 format from any software in place at pharmacies. ***ProNET*** supports X.25 communications protocol for in-bound prescription traffic, and SNA, BiSync, X.25 and other communications protocols for direct connect to all major third party administrators.

On-line Third Party Rx Editing

Third party prescriptions which are to be adjudicated on-line by a third party administrator are edited twice by ***ProINTERCEPT***, once during Pre-Adjudication to audit the pharmacist product selection against known administrator edits, and again during Post-Adjudication to audit the administrator against anticipated pricing responses within centrally prescribed thresholds.

Pre-Adjudication is the process of centrally reviewing, editing and pricing prescriptions prior to completing the dispensing of the medication by the in-store pharmacist or switching the transaction to a third party administrator for adjudication.

Post-Adjudication is the process of integrating information from all sources prior to dispensing the prescription's medication by the in-store pharmacist.

Pre-Adjudication edits which determine that the pharmacist product selection, quantity, dosing, days supply, etc. are outside the administrators thresholds, or may result in unwanted approvals from the administrator, will prevent the prescription from being forwarded on for adjudication. This saves unnecessary communications expense as well as losses resulting from unwanted approvals below expected reimbursement levels.

Post-Adjudication edits which determine that the administrator?s approval amounts fall below expected reimbursement levels may be reversed in-flight or noted and indicated to the pharmacist via standard NCPDP messaging facilities. Post-Adjudication guarantees that copays are calculated according to guidelines set by corporate even if an administrator's system is incapable of properly calculating the plan defined copayment amount. Transactions resulting in a plan sponsor having no financial responsibility can finally be managed according to what's best for both the patient and the provider, under control of the provider and not the administrator.

Unique to the ***ProINTERCEPT*** application is the ability to "capture" profiled but unapplied edits which, via ***ProANALYST***, can predict the effect of such prescription edits without imposing them immediately. In this way, central office personnel can make informed decisions about the applicability of certain types of prescription edits before actually applying them.

Non-Online Insurance Prescriptions

Prescriptions not yet adjudicated on-line can be edited by ***ProINTERCEPT***, validating the pharmacist product selection, plan sponsor prescription limitations and reimbursement guidelines. This results in reduced bad debt, decreased partial payments, decreased store labor, and eliminates the need for pre-edits which may currently be done by other processors

Cash Prescription Processing

Cash prescriptions submitted by pharmacies are audited against centrally defined edit and pricing criteria.

The edits ensure product selection is controlled at corporate, to maximize the pharmacy chain's financial consideration from manufacturers for product conversion incentives and rebates. A central office mandate to change generic manufacturers is implemented smoothly and efficiently. Special system-wide edits provide for immediate termination of all dispensing of recalled products.

Pricing criteria can be managed by corporate by updating all pricing tables on the PHI ***ProINTERCEPT*** system. Virtually any pricing algorithm can be implemented via special application programming interfaces specific to each customer. This guarantees that a client's cash pricing remains proprietary, while providing for the chain's competitive sensitivities within markets via pharmacy designations. Reporting by ***ProANALYST*** provides profitability grouped by Region, District, and/or Market.

Drug Utilization Review

Any or all prescriptions may be profiled, to participate in on-line Drug Utilization Review edits. These edits occur after Pre-Adjudication for cash and non-on-line third party transactions, and during adjudication for on-line third party transactions.

If so profiled, the ***ProINTERCEPT*** application will invoke a specially created version of the MediSpan THE SOLUTION? application. Modified for the demanding requirements of high-performance on-line transaction processing, this application will edit the inflight prescription against all prior historical prescriptions for the same patient for:

Features

- Drug-Drug Interactions.
- Duplicate Drug Therapies.
- Over/Under Dosing.
- Drug Therapy Duration.
- Patient Compliance.
- Early Refill.
- Implicit Medical Conditions.

ProINTERCEPT analyzes and validates the prescription being dispensed against the global database of information of prior prescriptions from all stores in the pharmacy chain.

Identification of the individual follows the NCPDP DUR work group committee?s recommended method of uniquely identifying individuals across plans. Optionally, these edits may be applied only for prescriptions under a single plan or filled only as cash.

Past experience of Prospective Health personnel indicates that patient profiles for retail patients are difficult, at best, to obtain and difficult to maintain. This decision is backed up by analysis from the NCPDP DUR committee, as documented in the second draft of the ORDUR (On-line Real Time DUR) Applications Manual. Further, the patient's allergies and medical conditions are best validated at store level. Most in-store pharmacy applications already provide this functionality. Thus ***ProINTERCEPT***, via MediSpan's DUR, will not edit against specific allergy and medical conditions unless the patient is "registered" on the central system, and his/her allergies and medical conditions have been profiled.

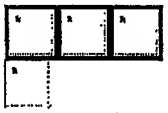
Last Updated: 02/17/97

EXHIBIT J

PHI ProANALYST

Access to information is critical. A system needs to provide quick and reliable information to both customers and management. The PHI ***ProINTERCEPT*** system provides this capability via the ***ProANALYST*** module. With over 100 standard reports, the system delivers a wide range of reports by carrier, plan, group, patient/member, provider (pharmacy and prescriber), drug manufacturer, drug class and dispensing patterns. Due to the relational technology of the system, all data fields are available for reporting purposes.

In addition, ***ProANALYST*** provides access to the centralized relational database via Structured Query Language (SQL). SQL allows ad hoc query and reporting against any combination of data elements contained in the database. This ability opens up a host of other possible opportunities for the retail pharmacy chain, ranging from marketing research, to patient compliance programs, comparative plan/group analysis, and provider peer review.



Last Updated: 03/11/97

EXHIBIT K

PHI ProPBM - Executive Summary

EXECUTIVE SUMMARY

The pharmacy benefit management (PBM) industry has matured in its use of previously developed computer hardware and software applications. Increasingly complex payer requirements relative to benefit design and new challenges for information access have caused pharmacy benefit management organizations to review their existing system capabilities.

Pharmacy providers have evolved in the use of more sophisticated point of sale computer systems. Similarly, PBM?s are finding it necessary to upgrade their own systems in order to keep pace with the industry and take advantage of opportunities associated with the control and management of prescription data.

Today, PBM?s are demanding software solutions which will allow them to obtain total centralized control of pharmacy providers and the resulting prescription data, so as to provide both cost savings and a higher level of patient care. The Prospective Health system is that solution.

PBM legacy systems are often designed around aging technology and are typically deficient in a number of areas, including:

- Benefit design flexibility.
- Effective formulary control.
- Edit capabilities.
- Drug Utilization Review.
- Provider audit capability.
- Cognitive Services tracking.
- Payer/Provider reporting.
- Advanced Pharmacy/Physician Networking.
- Client/Server Architechture.
- Intuitive user interface.

ProPBM effectively addresses these issues. On the following pages you will find an overview of the ***ProPBM*** system capabilities. We encourage you to examine this in detail and to contact us for a demonstration of the system. Thank you for your interest in PHI.

Last Updated: 05/22/97

EXHIBIT L

ProPBM - Overview

ProPBM is the pharmacy benefit management solution for centralized editing, adjudication, and control of multiple provider sites for pharmacy benefit management organizations.

Since the system operates in a real time, client/server environment, ***ProPBM*** edits or edit changes take effect immediately. This ensures accurate adjudication according to pricing and benefit parameters defined by the pharmacy benefit management organization

The same control applies to all aspects of the system, including; plan formularies, pharmacy and physician networks, pricing, MAC lists, copay schedules, etc.

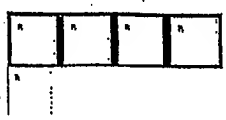
ProNET, the system?s switch module, handles point-of-service prescription transactions in the NCPDP's standard 3.2 format from any software in place at pharmacies. ***ProNET*** supports X.25 communications protocol for in-bound prescription traffic, and SNA, BiSync, X.25 and other communications protocols for direct connect to all major third party administrators.

Additionally, the system allows you to profile any or all prescriptions for on-line Drug Utilization Review by way of a specially created version of MediSpan?s THE SOLUTION ? application. Modified for the requirements of high performance on-line transaction processing, this application edits the prescription against prior database history. Identification of the patient/member follows the NCPDP recommended method of uniquely identifying individuals.

Selected system capabilities:

- Complete member eligibility tracking.
- Sophisticated help desk system(ProHelpDesk).
- Comprehensive pricing routines for copays, ingredient costs, and cognitive fees.
- Support of both "positive" and "negative" formularies at the drug store and drug class levels.
- Edits for "network" provider - both pharmacy and prescriber.
- Tracking of patient/member deductibles.
- Adjudication guidelines defined at the carrier, plan, group, and sub-group levels.
- Maximum/Minimum quantity based on days supply or units dispensed.
- Maintenance dosing controls.
- Accomodate special billing formats.
- Early/Late Refill controls.

ProPBM will process over 200 million transactions in 1997!



Last Updated: 05/22/97

EXHIBIT M

PHI ProINTERCEPT - Executive Summary

EXECUTIVE SUMMARY

In recent years, the retail drug industry has matured in its use of in-store computer equipment and software. Driven to respond to the requirements of third party prescription drug programs and manufacturer price increases, virtually every pharmacy today is computerized.

As the implementation of pharmacy in-store systems evolved, most retailers were submerged with the efforts involved in the process itself, and management of the retail chain's distributed systems has been accomplished via off-hours transfer of information in batch mode.

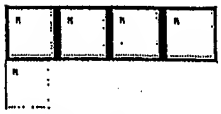
This approach has allowed a limited information exchange between the central office and each remote "island of information", but provides no solution for current pressing industry issues.

Today, pharmacy managers are demanding software solutions which will allow them to obtain total, centralized control of their "islands" so as to provide both cost savings and better patient care.

The corporate office is demanding:

- Centralized Formulary Controls.
- Centralized Pricing Management.
- Centralized Inventory Controls.
- The ability to manage constantly changing and increaseingly complex third party drug program requirements.
- Centralized prescription history, facilitating chain-wide Drug Utilization Review.
- The ability to manage pharmacy dispensing patterns and to report on Cognitive Service performed by the pharmacy provider.
- Validation of increasingly complex dispensing decisions made by their pharmacists.
- On-line, prospective audits of third party administrators' adjudication decisions prior to the dispensing of medications to patients.

ProINTERCEPT effectively addresses these issues. On the following pages you will find an overview of the ***ProINTERCEPT*** system capabilities. We encourage you to examine this in detail and to contact us for a demonstration of the system. Thank you for your interest in PHI



Last Updated: 05/22/97

EXHIBIT N

Hello, and thanks for stopping by the ***Prospective Health, Inc.*** *website. PHI is an industry leader in developing OLTP Client/Server applications for the pharmacy industry. On the following pages you will find highlights about PHI's applications. Please feel free to contact us at (800) 305-5577 with any questions you may have.*

- PHI ProINTERCEPT
- PHI ProPBM
- PHI ProANALYST
- PHI - Business News
- PHI Officer Profiles
- PHI Employment Opportunities

Last Updated: 07/28/98

EXHIBIT O

78 of 137 DOCUMENTS

USA TODAY

December 10, 1997, Wednesday, FINAL EDITION

SECTION: MONEY; Pg. 1B

LENGTH: 265 words

HEADLINE: A 'smart card' for medical bills?

BYLINE: Steven Findlay

BODY:

A service launched Tuesday could ease one of the most annoying headaches of modern times: the processing of medical bills.

The initiative by several technology companies -- including MCI and Digital Equipment -- pairs a "smart card," which looks like a credit card and has a microchip, with new software to process bills electronically and instantaneously.

Insurers and managed care companies would give enrollees a card containing their coverage information. The technology consortium would lease computers and software to doctors, hospitals and other health providers for $ 250 a month.

Payment processing would start with a swipe of the card in a doctor's office. Patients would see what their insurance will pay before leaving.

"We think this will reengineer how Americans pay for health care," says Mark Morris, co-founder of RealMed, the consortium's lead company. Gemplus, a French firm, will provide the smart cards.

About 40% of the 3.7 billion medical bills issued each year are processed electronically. Even so, insurers take an average of a month to pay. About 30% of claims must be refiled or reviewed. Average processing cost: $ 12 per claim.

Consortium members aim to pay doctors in 48 hours, cut the costs per claim roughly in half and slash the error rate.

"This sounds almost too good to be true," says Frank Goldstein, director of the Summit Medical Group in New Jersey, an 85-doctor practice. "I'll believe it when I see it."

The service won't be available until March or April, and no one has signed up for it yet.

LOAD-DATE: December 10, 1997

EXHIBIT P

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RealMed launches local pilot in Indy

RealMed Corp. is in the midst of a pilot program in Indianapolis that will either prove or disprove a system it has developed over several years to slash the time and expense of processing health insurance claims.

Not surprisingly, managers at the far-north-side start-up are optimistic.

"We think this [pilot] will prove the technology in the marketplace," said spokesman Dan Perrin.

That technology centers on a "smart card" patients use in lieu of the traditional insurance card. The card carries a microprocessor loaded with information about a person's health background, insurance plan and demographics.

Presented at a doctor's visit, it is designed to act like a debit card for insurance claims, resolving them at the point of service and cutting processing expenses for both physicians and payers.

Backed by MCI, Digital Equipme and smart-card maker Gemplus, the firm spent about five years working on the system.

RealMed officials are hoping for good results to shop around to investors and potential investors, and to recruit health insurance companies to the network.

While not identifying the insurance company or the physicians participating in the program, Perrin said the pilot involves 500 physicians from a range of specialties.

RealMed plans to release results of the project, launched in mid-September, in early November. Later that month, the company—which has satellite offices in Chicago and Lansing, Mich.—will announce when and in which city it will take the network live, Perrin said.

RealMed was spun off from locally based Eclipse America Corp. in 1995. It grew out of Eclipse's development of software for medical savings accounts, which are essentially tax-free savings accounts for health care expenses.